

The Medicare Advantage Program and MedPAC Recommendations

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Statement of
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Chairman Spratt, Ranking Member Ryan, distinguished Committee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss the Medicare Advantage program and recommendations that the Commission has made for the program.

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the Congress on issues affecting the Medicare program. MedPAC makes recommendations on payment policy for providers in Medicare's traditional fee-for-service program and for Medicare Advantage organizations. MedPAC also analyzes beneficiary access to care, quality of care, and other issues affecting Medicare.

The Commission's 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. The Commission is supported by a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

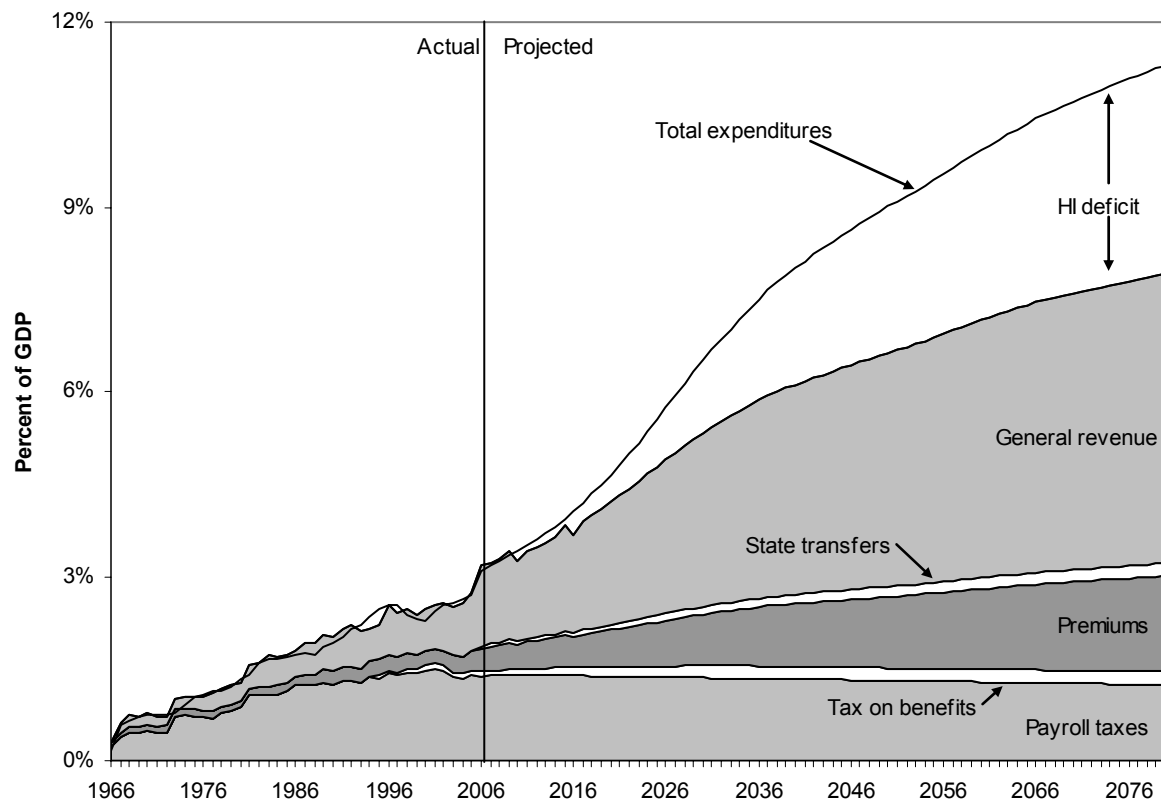
Several principles guide the Commission's work. First, Medicare beneficiaries need to have access to high quality care. Second, taxpayer dollars should be spent wisely. Third, providers should be paid fairly to serve Medicare beneficiaries and those payments should encourage efficiency and quality. In short, the Commission strives to make Medicare a more efficient program while at the same time improving the quality of care beneficiaries receive.

The Commission believes that greater efficiency is achieved when organizations face financial pressure. The Medicare program needs to exert consistent financial pressure on both the traditional fee-for-service (FFS) program and the Medicare Advantage (MA) program. This financial pressure, coupled with meaningful measurement of quality and

resource use in order to reward efficient care, will maximize the value of Medicare for the taxpayers and beneficiaries who finance the program.

The Commission is acutely aware of the long-run sustainability issues facing Medicare. Figure 1 shows the Medicare trustees' view of the future of Medicare financing. Total expenditures for Medicare will take up an increasing share of the nation's gross domestic product (GDP) and quickly exceed dedicated financing. In their most recent report, the Medicare trustees project that, under intermediate assumptions, the hospital insurance (HI) trust fund (which finances Part A of Medicare) will be exhausted in 2019. There is no provision to use general revenues to cover Part A services once the HI trust fund is exhausted. Consequently, either those expenditures will have to cease or some new source of financing will have to be found. For other parts of Medicare (Part B and Part D), general tax revenues and premiums automatically increase with expenditures. Those automatic increases will impose a significant financial liability on Medicare beneficiaries, who must pay premiums and cost sharing, and on taxpayers in general. For example, if income taxes remain at their historical average share of the economy, the Medicare trustees estimate that the program's share of personal and corporate income tax revenue would rise from 10 percent today to 24 percent by 2030.

Figure 1. Medicare faces serious challenges with long-term financing

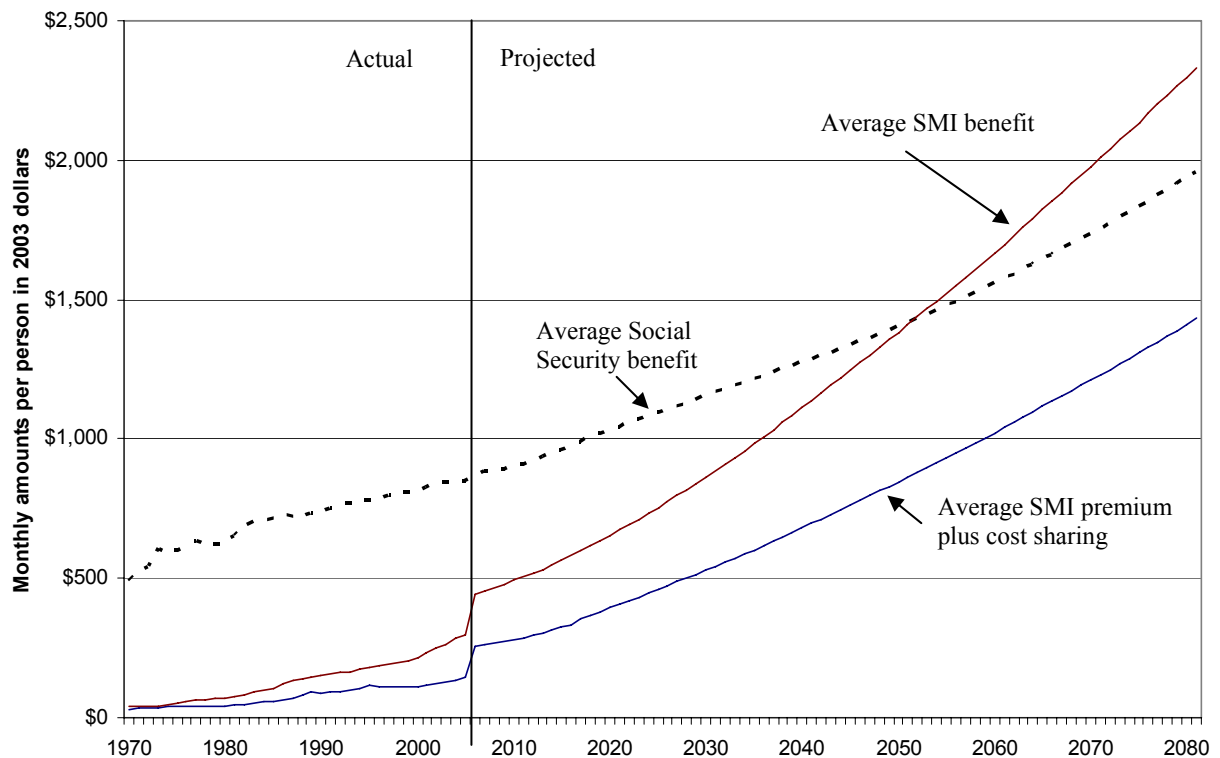


Note: GDP (gross domestic product), HI (Hospital Insurance). Tax on benefits refers to income taxes that higher income individuals pay on Social Security benefits that are designated for Medicare. State transfers (often called the Part D "clawback") refer to payments from the states to Medicare for assuming primary responsibility for prescription drug spending.

Source: 2007 annual report of the Boards of Trustees of the Medicare trust funds.

Figure 2 shows that between 1970 and 2005, the average monthly Social Security benefit (adjusted for inflation) increased by an annual average rate of 1.6 percent. Over the same period, average supplementary medical insurance (SMI) premiums plus cost sharing and average SMI benefits grew by annual averages of 4.5 percent and 5.9 percent, respectively. In the 2003–2006 period, Part B premium increases offset 20 percent to 40 percent of the dollar increase in the average Social Security benefit. For 2007, the increase in the Part B premium offsets 13 percent of the Social Security benefit increase. Medicare trustees project that between 2006 and 2036, the average Social Security benefit will grow by just over 1 percent annually (after adjusting for inflation), compared with 3 percent annual growth in average SMI premiums plus cost sharing.

Figure 2. Average monthly SMI benefits, premiums, and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs prior to 2006 is not included.

Source: 2007 annual report of the Board of Trustees of the Medicare trust funds.

Medicare's private plan option was originally designed as a program that would produce efficiency in the delivery of health care. Through the use of coordinated care techniques, selected provider networks and negotiated fees, plans would be more efficient than the traditional FFS program. Efficient plans would be able to provide extra benefits to enrollees choosing to enroll in such plans, and this in turn would lead to higher plan enrollment. Unfortunately, MA has instead become a program in which there are few incentives for efficiency. Although MA uses "bidding" as the means of determining plan payments and beneficiary premiums, the bids are against administratively-set benchmarks. Setting benchmarks well above the cost of traditional Medicare signals that

the program welcomes plans that are more costly than traditional Medicare. Put differently, inefficient plans—as well as efficient plans—are able to provide the kind of enhanced coverage that attracts beneficiaries to private plans because of generous MA program payments. These additional payments are funded by all taxpayers. Furthermore, all Medicare beneficiaries—not just the 18 percent of beneficiaries enrolled in private plans—pay higher Part B premiums to fund these payments in excess of Medicare FFS levels.

MedPAC's recommendations on private plans in Medicare and transition approaches

MedPAC has a long history of supporting private plans in the Medicare program. The Commission believes that Medicare beneficiaries should be able to choose between the FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans may have greater flexibility in developing innovative approaches to care, and these plans can more readily use tools such as negotiated prices, provider networks, care coordination and other health care management techniques to improve the efficiency and quality of health care services.

The Commission believes that payment policy in the MA program should be built on a foundation of financial neutrality between payments in the traditional FFS program and payments to private plans. Financial neutrality means that the Medicare program should pay the same amount, adjusting for the risk status of each beneficiary, regardless of which Medicare option a beneficiary chooses. This approach underpins many of the recommendations that the Commission has made to improve the MA program, which are shown in the text box, p. 15.

Current MA program payment rates reflect previous statutory changes that provided for minimum payment levels in certain counties, which were often well above FFS levels. These inflated benchmarks, coupled with the distribution of MA enrollment across the country, undermine the goal of financial neutrality. Currently, program payments for MA plan enrollees are well above 100 percent of FFS expenditure levels: on average, MA program payments are at 112 percent of Medicare FFS levels. Note that benchmarks vary

by county, and so payment levels to plans vary among plan types, based on where their enrollment is concentrated. In 2006, payment levels ranged from 110 percent of FFS for HMOs to 119 percent of FFS for private fee-for-service (PFFS) plans.

To pay MA plans appropriately, the Commission recommends that benchmarks—the basis of plan payments in MA—should be set at 100 percent of Medicare FFS expenditures. The Commission first made this financial neutrality recommendation in March 2001. For the past several years, we have analyzed payments to private plans compared to FFS and have found consistently that plan payments exceed FFS expenditure levels.

The excess payments to private plans allow them to be less efficient than they would otherwise have to be, because inefficient plans can use the excess payments—rather than savings from efficiencies—to finance extra benefits that in turn attract enrollees to such plans. As shown in Table 1, enrollment has grown substantially in MA as result of this situation.

Table 1. Enrollment has grown substantially in the Medicare Advantage program in the last two years

Plan type	Enrollment			Net enrollment growth	
	December 2005	July 2006	February 2007	Dec. 2005 to July 2006	July 2006 to Feb. 2007
Local HMOs and PPOs	5,157,627	5,479,630	6,064,666	6%	11%
PFFS	208,990	773,553	1,327,826	270%	72%
Regional PPOs	None available	81,785	120,770	N/A	48%

Note: PPO (preferred provider organization), PFFS (private fee-for-service), N/A (not applicable). Table does not include special needs plans or employer-only plans.

Reducing benchmarks would mean that plans could only provide benefits through their efficiencies relative to FFS. This would result in fewer plan offerings and less generous benefits. Because of the impact on plan enrollees, the Congress may wish to employ a transition approach in implementing the Commission’s recommendation on payment rates. Possible approaches might be to (a) freeze all county rates at their current levels

until each county's rate is at the FFS level, with a possible minimum yearly update; (b) cap the percentage by which county rates can exceed FFS levels and then gradually lower the cap; (c) use a blend of 100 percent of FFS levels and Medicare Advantage county rates and gradually over time increase the portion attributable to 100 percent of FFS in the blend; or, (d) use competitive bidding to set rates, using plan bids as a factor in determining county rates.

Efficiency in Medicare Advantage and extra benefits

Historically, policymakers have tried to structure the Medicare private plan program so that efficient plans could provide extra benefits to plan enrollees. To the extent that a private plan could provide care more efficiently than FFS Medicare, the plan could use its efficiency gains to finance extra benefits—reduced out-of-pocket costs, and coverage of services Medicare did not cover, such as dental, hearing, vision services, and (most importantly before the advent of Part D) outpatient prescription drugs. The ability to offer extra benefits would attract beneficiaries to enroll in these plans. Having plans compete against each other would also promote efficiency. In a system in which plan payments are appropriately risk-adjusted, a richer benefit package would generally signal that one plan was more efficient than another competing plan—and that a private plan offering extra benefits was more efficient than the traditional Medicare FFS program in the plan's market area.

There are efficient plans operating in the MA program. Such plans are able to provide the traditional Medicare Part A and Part B benefit at a lower cost than the FFS program. As shown in Table 2, on average in 2006, HMO plans were able to provide the traditional Medicare benefit for 97 percent of Medicare FFS expenditure levels. Because, in 2006, HMOs had such a large share of the overall enrollment, on average across all plan types, the “bid” for traditional Medicare services was 99 percent of Medicare FFS expenditures.

Table 2. MA plan payments relative to Medicare FFS spending by plan type, weighted by enrollment, and plan enrollment, July 2006

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Bid (for Medicare A/B benefit) in relation to FFS	99	97	108	103	109
Rebate as percent of FFS	13	13	9	7	10
Payment (bid + rebates)/FFS	112	110	117	110	119
Enrollment (in thousands) as of July 2006	6,877	5,195	285	82	774

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service). Special needs plans and employer-only plans are included in all-plan total but plan data not shown.

Table 2 indicates the level of “rebates” or extra benefits that plans provide at no charge to the enrollee, expressed as a percent of Medicare FFS expenditures for the geographic areas from which plans draw their enrollment. These rebate amounts are determined based on the plan bid and its relation to the area “benchmark,” which is the maximum program payment to an MA plan in a given county or geographic area and which is often well above the FFS level. If a plan is able to provide the traditional Medicare benefit package for less than the benchmark level, enrollees receive extra benefits valued at 75 percent of the difference between the benchmark and the plan bid for the Medicare package (with 25 percent of the difference retained by the Medicare Trust Funds). (Plans may also provide extra benefits that enrollees pay for through an additional premium to the plan.)

Except in the case of regional PPO plans, benchmarks are set at the county level. The benchmarks vary significantly from county to county, and the difference between a given county’s benchmark and FFS expenditure levels in the county can also vary significantly, although in no case is the FFS level above the MA benchmark. Table 3 shows the ratio of benchmarks to FFS expenditure levels for the different plan types in July of 2006, based on the counties from which the plans drew their enrollment.

Table 3. MA benchmarks by plan type, compared to Medicare fee-for-service expenditure levels, weighted by enrollment, July 2007

	All MA plans with bids	HMO	Local PPO	Regional PPO	PFFS
Benchmark/FFS expenditures	116	115	120	112	122

Note: MA (Medicare Advantage), FFS (fee-for-service), PPO (preferred provider organization), PFFS (private fee-for-service).

PFFS plans, for example, are primarily drawing their enrollment from higher-benchmark counties—specifically counties that were historically “floor” counties. MA benchmarks in these counties are established by statutory formula, resulting in benchmarks far above FFS expenditure levels in most cases. While PFFS plans are drawing enrollment from floor counties, HMOs are drawing their enrollment from counties where benchmarks are closer to Medicare FFS expenditure levels.

Enrollment trends in relation to payment

Within MA, PFFS is by far the fastest growing type of plan (see Table 1). If current enrollment patterns continue—with PFFS growing more rapidly than other plans and continuing to draw enrollment from higher-benchmark counties—the difference between Medicare FFS expenditure levels and MA payment rates will widen further. More enrollees will come from counties with very high benchmarks in relation to FFS. If continued, this enrollment trend will counteract the phase-out of the “hold-harmless” provision, which would otherwise narrow the difference between FFS and MA payment levels.

The hold-harmless provision affects risk-adjusted payments to MA plans. Plan enrollees, on average, are healthier than beneficiaries in FFS Medicare. Under the current system, though payments at the individual beneficiary level are fully risk adjusted for health status as of 2007, plans receive an additional payment during a phase-out period. During the phase-out period, plans are paid a portion of the difference between risk-adjusted payments and the payment that would have been made without the health status risk adjustment. This approach is being phased out over the next few years to move towards payments solely at the risk-adjusted level. The net result of phasing out the hold-

harmless provision would have been an overall reduction in average plan payments. However, we are concerned that the opposing MA enrollment trend could potentially eclipse the effect of the phase-out of the hold-harmless provision, and thus continue higher overall MA payments.

Varying efficiency among different types of plans

Table 2 also illustrates that there is varying efficiency among plan types in MA. While HMOs can provide the Medicare benefit at 97 percent of Medicare FFS costs, as noted above, not all plans achieve the same level of efficiency. At the other end of the scale from HMOs are PFFS plans. From a taxpayer point of view, PFFS plans are paid 9 percent more than Medicare FFS, on average, to provide the traditional Medicare FFS benefit package. Although PFFS plans provide enrollees with rebates valued at about 10 percent of Medicare FFS expenditures, program payments on behalf of PFFS enrollees are 19 percent above FFS expenditure levels—so only about half of the excess amount is used to finance extra benefits for enrollees. More over, all of the extra benefits provided by PFFS plans are financed by the overpayments.

For HMOs, what the 97 percent means is that, on average across HMO plans, some of the extra benefits are financed by rebate dollars that are generated because these plans can provide the Medicare benefit package more efficiently than the Medicare FFS program in the counties where HMOs have their enrollees. This also means is that, if benchmarks are reduced, there could still be extra benefits provided to enrollees in the MA program. It is not the case that, if benchmarks were reduced to 100 percent of FFS, no plans would be able to provide extra benefits. But as we pointed out above, there would likely be fewer plan choices and less generous plans in some markets.

Equity between sectors and among plan types

The Commission supports equity between the two sectors—the Medicare private plan sector and traditional Medicare. Supporting the principle of equity between the sectors takes many forms. For example, most of the private plans participating in Medicare are required to report various types of quality measures. The Commission believes that the same approach should apply in the traditional FFS program. That is, there should be

quality information reported for FFS Medicare that allows Medicare beneficiaries to compare FFS Medicare with private plans in terms of their performance on quality measures. To that end, the Commission has specifically recommended that the Secretary of Health and Human Services should calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

The Commission also supports the concept of equity in the treatment of different plan types. For example, the Commission recommended that the Congress eliminate the benefit stabilization fund, which provided an unfair advantage to the regional preferred provider organizations introduced in the Medicare Modernization Act (see text box, p. 15). Similarly, the Commission finds that, relative to other plans, there are advantages currently in place for special needs plans, PFFS plans, and medical savings account (MSA) plans in the MA program.

Table 4 illustrates the ways in which different requirements apply to different plan types in MA. In general, the Commission favors a level playing field for all plan types, with no plan type having an advantage over another plan type. The Commission believes, for example, that PFFS plans and MSA plans should be required to report on the quality of care for their enrollees so that beneficiaries can use quality as a factor in judging these plans. Payment rules that give one plan an advantage over another—as described above with regard to regional PPO plans—should be eliminated. The MSA plan option raises this question: why are these plans not required to have 25 percent of the difference between the MSA plan bid and the benchmark retained in the Trust Funds, as is the case for other plan types?

Table 4. Different requirements and provisions apply to different types of Medicare Advantage plans

	PFFS	MSA	HMO/Local PPO	Regional PPO	SNP
Must build networks of providers			✓	✓	✓
Must report quality measures			✓	✓	✓
Must have CMS review and approve bids			✓	✓	✓
Must return to the Trust Funds 25 percent of the difference between bid and benchmark	✓		✓	✓	✓
Must offer individual MA plan if offering employer group plan*			✓	✓	✓
Must offer Part D coverage			✓	✓	✓
Must have an out-of-pocket limit on enrollee expenditures		✓		✓	
Can limit enrollment to targeted beneficiaries					✓

Note: MA (Medicare Advantage), PFFS (private fee-for-service), MSA (medical savings account), PPO (preferred provider organization), SNP (special needs plan).

*Effective as of 2008 contract year; requirement does not apply to PFFS and MSA plans.

Source: MedPAC analysis of MA statutory and regulatory requirements.

Efficiency in MA and broader equity issues

Some argue that paying plans more than FFS is a worthwhile expenditure because plans provide extra benefits to enrollees. While it is true that plans provide extra benefits, some equity and efficiency issues need to be considered. The overarching equity issue is that all beneficiaries and all taxpayers are paying the cost in excess of Medicare FFS when payments to plans exceed 100 percent of Medicare FFS expenditure levels. When MA rebate dollars exist only because MA program payments are far higher than expenditures in the FFS program—not because plans are being efficient—then the extra benefits are being funded through taxes from all taxpayers, and Medicare Part B premiums from all Medicare beneficiaries, not just those enrolled in these plans. Only

some Medicare beneficiaries, therefore, derive a benefit from the way in which the MA program is financed, while the majority of Medicare beneficiaries are paying for the benefits that only some beneficiaries receive. To quantify what this means, the Medicare actuary recently testified in front of the House Ways and Means Committee that on average every Medicare beneficiary is paying about \$2.00 more per month in his or her Medicare Part B premium to finance the payments being made in MA that exceed Medicare FFS expenditure levels.

If the justification for higher payments to plans is that extra benefits are being provided to low-income beneficiaries who choose these plans, there are less more targeted ways to achieve this result—the Medicare savings program, for example, or the approach used for low-income subsidies in Part D. What is occurring now is that the most inefficient plans are expanding their enrollment, and providing extra benefits only with taxpayer dollars. In fact, these plans need additional taxpayer dollars just to provide the Part A and B benefit. The longer the current situation continues, the more difficult it will be to reform the program to restore the right incentives in the MA program to promote efficiency and improved quality. As millions of beneficiaries enroll in products shaped by the current policy, it will become ever more difficult to change direction. Put differently, a major expansion of Medicare benefits will have occurred without a discussion of who is eligible, what benefits to provider, and how to pay for them. As difficult as it seems today, it will be even more difficult next year or the year after. The constituency with a stake in the current policy, both plans and beneficiaries, will be that much larger. This is especially worrisome given that the most heavily subsidized and fastest growing plans are the least efficient ones.

If beneficiaries are able to choose between Medicare FFS and an array of private plans—and if the Medicare program pays the same on behalf of the beneficiaries making the choice—then over time, beneficiaries will gravitate either to the FFS system or to the plan that provides the best value in terms of efficiency and quality. The Medicare program would not subsidize one choice more than another. The Medicare program should be financially neutral regarding whether the beneficiary chooses to remain in the

FFS system or enroll in a plan. This neutrality provides beneficiaries with the incentive to select the system that they perceive as having the highest value.

The equity and efficiency issues that we have described here are of particular concern in an era in which Medicare is facing long-run sustainability issues. We should take all steps possible to promote efficiency in both FFS Medicare and in MA. The Medicare program should strive towards improving plan efficiency by paying appropriately, by ensuring a level playing field between FFS and MA plans and among MA plans. The basic question for us is, "What kind of plans do we need to participate in Medicare?" Given Medicare's sustainability issues, the obvious answer is more efficient plans. However, the current benchmarks are sending the opposite signal to plans and beneficiaries. Overpaying in the short run is never a strategy for achieving long-run efficiency.

Medicare Advantage recommendations from MedPAC's June 2005 Report to the Congress

MA recommendations from the June 2005 Report to the Congress are summarized below:

- A number of MMA provisions give the new regional PPOs a competitive edge over other plans, as well as added funding. One provision is the regional stabilization fund, initially funded at \$10 billion. The Commission recommended that the Congress eliminate the stabilization fund for regional PPOs.
- Regional PPOs can have an advantage over local plans as a result of the MA bidding process. Because of the different method used to determine benchmarks for regional PPOs in relation to the method used for other plans, and because of the bidding approach used for regional plans, there can be distortions in competition between regional and local plans. The Commission recommended that the Congress clarify that regional plans should submit bids that are standardized for the region's MA-eligible population.
- MA rates include medical education payments, but at the same time Medicare makes separate indirect medical education payments to hospitals treating MA enrollees. The Commission recommended that the Congress remove the effect of payments for indirect medical education from the MA plan benchmarks.
- The Commission has consistently supported the concept of financial neutrality between payment rates for the FFS program and private plans, with equitable payments among private plans. The Commission recommended that the Congress set the benchmarks that CMS uses to evaluate Medicare Advantage plan bids at 100 percent of fee-for-service costs. However, the Commission recognizes that higher MA rates reflect the desire of Congress to expand the availability of plans and that payment reductions may result in disruptions for beneficiaries and for plans, so that benchmarks may need to be adjusted differentially across the country.
- The Commission believes that pay-for-performance should apply in MA to reward plans that provide higher quality care. Funding can come from the amounts that are retained in the Trust Funds when plans bid below benchmarks, as recommended by the Commission in stating that the Congress redirect Medicare's share of savings from bids below the benchmarks to a fund that would redistribute the savings back to MA plans based on quality measures.
- The Commission believes that more can be done to facilitate beneficiary choice and decision making by enabling a direct comparison between the quality of care in private plans and quality in the FFS system. The Commission therefore recommended that the Secretary calculate clinical measures for the FFS program that would permit CMS to compare the FFS program to MA plans.

Another recommendation the Commission made in 2005 was a provision of the Deficit Reduction Act. This specified in statute the time line for phasing out the hold-harmless policy that offsets the impact of risk adjustment on aggregate plan payments through 2010.